State of California Department of Consumer Affairs

BOARD OF REGISTERED NURSING
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www.rn.ca.gov

VERIFICATION OF THE COMPLETION OF A PSYCHIATRIC/MENTAL HEALTH (P/MH) ACADEMIC PROGRAM

A. TO BE COMPLETED BY APPLICANT: Please complete Section A and forward to the program director/representative for the Psychiatric/Mental Health nursing academic program for completion. Official transcripts submitted must include all completed course work with the master's degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts. Please print or type.

Name: (Last) (First) (Middle)	Previous Names (Including Maiden Name):
Address: (Number & Street)	Date of Birth: (Month) (Day) (Year)
(City) (State) (Zip Code)	Social Security Number (Mandatory):
Telephone Number: Home ( ) Work ( )	California RN License Number: Expiration Date:
Name of Master's Degree Nursing Program:	
Entrance and Completion Dates:	Specialty:
Signature of Applicant:_____	Date:_____

B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE PSYCHIATRIC/MENTAL HEALTH NURSING ACADEMIC PROGRAM: Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Master's Degree Nursing Program:	Telephone Number: ( )
Address: (Number & Street) (City) (State) (Zip Code)	
Nursing Specialty:	Date Master's Degree Status Conferred:
Entrance and Completion Dates: From: (Month) (Day) (Year)	To: (Month) (Day) (Year)

I certify under penalty of perjury that the documentation regarding the completion of the Psychiatric/Mental Health master's nursing academic program for the above named applicant is true and correct.

Signature:_____ Date:_____

Title:_____ Telephone Number:(_____)_____